

## DEPARTMENT OF HEALTH SERVICES

14744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 322-1584



Date Issued: January 16, 1996

CMSP Letter: 96-1

To: All County Medical Services Program (CMSP) County Welfare Directors

Subject: REVISED CMSP NOTICE OF ACTION - CHANGE IN SHARE OF COST  
(FORM CMSP 239 C, ENGLISH AND SPANISH VERSIONS)

This letter transmits two camera ready copies of the revised English and Spanish versions of the County Medical Services Program (CMSP) Notice of Action - Change in Share of Cost (Form CMSP 239 C). Counties should use these camera ready masters to produce a prudent supply of these revised forms. Previous revisions of these forms should no longer be used.

If you have any questions about this letter please contact Ms. Genny Fleming of my staff at (916) 327-3867. Thank you for your attention to this matter.

Sincerely,

Jim Martinez, Chief  
County Medical Services Program  
Unit

Enclosures

cc: Mr. Albert Cooper  
Office of County Health Services  
Department of Health Services  
1800 3rd Street, Room 100  
P.O. Box 942732

**COUNTY MEDICAL SERVICES PROGRAM  
NOTICE OF ACTION  
CHANGE IN SHARE OF COST**

(COUNTY STAMP)

CASE NAME: \_\_\_\_\_

CASE NO.: \_\_\_\_\_

DISTRICT: \_\_\_\_\_

CHANGE IN SHARE OF COST FOR \_\_\_\_\_

(Names)

Your share of cost has been changed to \$ \_\_\_\_\_ per month beginning \_\_\_\_\_ because:

Your new share of cost was determined as follows

Monthly Gross Income \$ \_\_\_\_\_

Monthly Net Nonexempt Income \$ \_\_\_\_\_

Maintenance Need \$ \_\_\_\_\_

Excess Income/Share of Cost \$ \_\_\_\_\_

The regulations which require this action are California Code of Regulations, Title 17, Section(s): 1498, et seq.

TAKE YOUR PLASTIC CARD TO YOUR MEDICAL PROVIDER WHENEVER YOU NEED CARE.  
DO NOT THROW AWAY YOUR PLASTIC ID CARD.

If you have questions about this action or if there are more facts about your conditions which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you.

\_\_\_\_\_  
Eligibility Worker\_\_\_\_\_  
Phone\_\_\_\_\_  
Date

**PLEASE READ THE REVERSE SIDE OF THIS NOTICE**